Summary of Benefits and Coverage: What this Plan Covers & What it Costs

Coverage Period: 01/01/2015 – 12/31/2015

Coverage for: Individual/Family | Plan Type: PPO



This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at <a href="https://www.anthem.com/ca/calpers">www.anthem.com/ca/calpers</a> or by calling 1-877-737-7776.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	For PPO Providers: <b>\$500</b> Member/ <b>\$1,000</b> Family For Non-PPO Providers: <b>\$500</b> Member/ <b>\$1,000</b> Family Does not apply to Preventive Care Services, Office Visits and Prescription Drugs.	You must pay all the costs up to the <u>deductible</u> amount before this plan begins to pay for covered service you use. Check your policy or plan document to see when the <u>deductible</u> starts over (usually, but not always, January 1 <sup>st</sup> ). See the chart starting on page 2 for how much you pay for covered services after you meet the <u>deductible</u> .
Are there other deductibles for specific services?	Yes. <b>\$250</b> /Admission for Non-Anthem Blue Cross PPO hospital or residential treatment center (waived for emergency admission). <b>\$50</b> /Visit for Emergency Room services (waived if admitted directly from ER).	You must pay all of the costs for these services up to the specific <u>deductible</u> amount before this plan begins to pay for these services.
Is there an <u>out-of-</u> <u>pocket limit</u> on my expenses?	For PPO Providers: \$4,600 Single/\$9,200 Family For Non-PPO Providers no out-of-pocket limit when using a Non-PPO providers.  Non-PPO Provider services do not count towards PPO Provider out-of-pocket.  For Pharmacy/Prescription Expenses: \$2,000 Single/\$4,000 Family	The <u>out-of-pocket limit</u> is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services with participating providers. This limit helps you plan for health care expenses.
What is not included in the <u>out-of-pocket limit?</u>	Premiums, balance-billed charges, Non-PPO Provider services, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u>
Is there an overall annual limit on what the plan pays?	No	The chart starting on page 2 describes any limits on what the plan will pay for specific coverage limits, such as limits on the number of office visits.

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Does this plan use a network of providers?	Yes. See <a href="www.anthem.com/ca/calpers">www.anthem.com/ca/calpers</a> for a list of PPO Providers or call 1-877-737-7776.	If you use an in-network doctor of other health care <b>provider</b> , this plan will pay some or all of the costs of covered services. Be aware, our in-network doctor of hospital may use an out-of-network <b>provider</b> for some services. Plan use the term in-network, <b>preferred</b> , or participating for <b>providers</b> in their <b>network</b> . See the chart starting on page 2 for how this plan pays different kinds of <b>providers</b> .
Do I need a referral to see a specialist?	No.	You can see the <b>specialist</b> you choose without permission from this plan.
Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed on page 7. See your policy or plan document for additional information about <u>excluded services</u> .



- Copayments are fixed dollar amounts (for example, \$15) you pay for covered health care, usually when you receive the service.
- <u>Coinsurance</u> is *your* share of the costs of a covered service, calculated as a percent of the <u>allowed amount</u> for the service. For example, if the plan's <u>allowed amount</u> for an overnight hospital stay is \$1,000, your <u>Coinsurance</u> payment of 20% would be \$200. This may change if you haven't met your <u>deductible</u>.
- The amount the plan pays for covered services is based on the <u>allowed amount</u>. If an out-of-network <u>provider</u> charges more than the <u>allowed amount</u>, you may have to pay the difference. For example, if an out-of-network hospital charges \$1,500 for an overnight stay and the <u>allowed amount</u> is \$1,000, you may have to pay the \$500 difference. (This is called <u>balance billing</u>.)
- This plan may encourage you to use PPO <u>providers</u> by charging you lower <u>deductibles</u>, <u>Copayments</u> and <u>Coinsurance</u> amounts.

Common Medical Event	Services You May Need	Your Cost If You Use a PPO Provider	Your Cost If You Use a Non-PPO Provider	Limitations & Exceptions
If you visit a health care	Primary care visit to treat an injury or illness	\$20 Copay/visit	<b>40%</b> Coinsurance of allowed amount	none
provider's office or	Specialist visit	\$20 Copay/visit	40% coinsurance of allowed amount	none

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clinic	Other practitioner office visit	Acupuncture & Chiropractic 10% Coinsurance	Acupuncture & Chiropractic 40% Coinsurance of allowed amount	Acupuncture and Chiropractic benefits are limited to a combined maximum of 20 visits per calendar year.
	Preventive care/screening /immunization	No Cost Share	<b>40%</b> Coinsurance of allowed amount	none
If you have a	Diagnostic test (x-ray, blood work)	Lab & X-Ray-Office 10% Coinsurance	<u>Lab &amp; X-Ray-Office</u> <b>10%</b> Coinsurance	none
test	Imaging (CT/PET scans, MRIs)	10% Coinsurance	40% Coinsurance of allowed amount	Pre-authorization required.
If you need drugs to treat your	Generic drugs	<b>\$5/</b> 34 day supply <b>\$10/</b> 90 day supply	Not Covered 100% Out of Pocket	After second fill you will pay the appropriate mail service copay for maintenance medications. 90 day supplies allowed at CVS Stores and CVS Caremark Mail Order.
illness or condition	Preferred brand drugs	<b>\$20/</b> 34 day supply <b>\$40/</b> 90 day supply	Not Covered 100% Out of Pocket	After second fill you will pay the appropriate mail service copay for maintenance medications. 90 day supplies allowed at CVS Stores and CVS Caremark Mail Order.
More information about prescription	Non-preferred brand drugs	<b>\$50/</b> 34 day supply <b>\$100/</b> 90 day supply	Not Covered 100% Out of Pocket	After second fill you will pay the appropriate mail service copay for maintenance medications. 90 day supplies allowed at CVS Stores and CVS Caremark Mail Order.
drug coverage is available www.caremar k.com/calper s	Specialty drugs	Specialty follows the tier structure above	Not Covered <b>100%</b> Out of Pocket	Specialty medication must be dispensed through CVS Caremark Specialty Pharmacy. All orders are dispensed 30 day supplies except RA/ MS medications.

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If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	10% Coinsurance	<b>40%</b> Coinsurance of allowed amount	Services and supplies for the following outpatient surgeries are limited: Colonoscopy limited to \$1,500 per procedure, Cataract surgery limited to \$2,000 per procedure; Arthroscopy limited to \$6,000 per procedure. Benefits limited to \$350 for ASC per day for Non-PPO providers.
	Physician/surgeon fees	10% Coinsurance	<b>40%</b> Coinsurance of allowed amount	none
If you need	Emergency room services	10% Coinsurance	10% Coinsurance of allowed amount	Additional deductible of <b>\$50</b> applies waived if admitted inpatient. This is for the hospital/facility charge only. The ER physician charge may be separate.
immediate medical	Emergency medical transportation	10% Coinsurance	10% Coinsurance of allowed amount	none
attention	Urgent care	\$20 Copay/Visit	<b>40%</b> Coinsurance of allowed amount	Costs may vary by site of service. You should refer to your formal contract of coverage for details.
If you have a hospital stay	Facility fee (e.g., hospital room)	10% Coinsurance	<b>40%</b> Coinsurance of allowed amount	\$250 Inpatient hospital deductible per admission. Hip and Knee joint replacement surgery will be limited to \$30,000 per procedure. A subset of participating hospitals meets this maximum benefit coverage. Preauthorization required.
	Physician/surgeon fee	10% Coinsurance	40% Coinsurance of allowed amount	none

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If you have	Mental/Behavioral health outpatient services	Mental/Behavioral Health Office Visit \$20 Copay/Visit Mental/Behavioral Health Facility Visit- Facility Charges 10% Coinsurance	Mental/Behavioral Health Office Visit 40% Coinsurance of allowed amount Mental/Behavioral Health Facility Visit- Facility Charges 40% Coinsurance of allowed amount	none
mental health, behavioral	Mental/Behavioral health inpatient services	10% Coinsurance	<b>40%</b> Coinsurance of allowed amount	This is for facility professional services only. Please refer to your hospital stay for facility fee.
health, or substance abuse needs	Substance use disorder outpatient services	Mental/Behavioral Health Office Visit \$20 Copay/Visit Mental/Behavioral Health Facility Visit- Facility Charges 10% Coinsurance	Substance Abuse Office Visit 40% Coinsurance of allowed amount Substance Abuse Facility Visit- Facility Charges 40% Coinsurance of allowed amount	none
	Substance use disorder inpatient services	10% Coinsurance	<b>40%</b> Coinsurance of allowed amount	This is for facility professional services only. Please refer to your hospital stay for facility fee.
If you are	Prenatal and postnatal care	10% Coinsurance	<b>40%</b> Coinsurance of allowed amount	none
pregnant	Delivery and all inpatient services	10% Coinsurance	<b>40%</b> Coinsurance of allowed amount	\$250 Inpatient hospital deductible per admission.

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	Home health care	10% Coinsurance	<b>40%</b> Coinsurance of allowed amount	Up to 100 visits per calendar year.
TC 1	Rehabilitation services	10% Coinsurance	<b>40%</b> Coinsurance of allowed amount	Up to 30 visits per calendar year for outpatient pulmonary rehabilitation. Up to 40 visits per calendar year coverage for outpatient cardiac rehabilitation.
If you need help	Habilitation services	10% Coinsurance	<b>40%</b> Coinsurance of allowed amount	All rehabilitation and habilitation visits count toward your rehabilitation visit limit.
recovering or have other special health needs	Skilled nursing care	10% Coinsurance For the first 10 days. 20% Coinsurance For the next 170 days.	<b>40%</b> Coinsurance of allowed amount	Up to 180 days maximum per calendar year. Preauthorization required.
	Durable medical equipment	10% Coinsurance	<b>40%</b> Coinsurance of allowed amount	none
	Hospice service	10% Coinsurance	<b>10%</b> Coinsurance of allowed amount	none
If your child	Eye exam	Not Covered	Not Covered	none
needs dental	Glasses	Not Covered	Not Covered	none
or eye care	Dental check-up	Not Covered	Not Covered	none

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#### **Excluded Services & Other Covered Services:**

<b>Services Your Plan Does NOT Cove</b>	(This isn't a complete list. Check your	ur policy or plan document for other excluded services.)
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Cosmetic surgery

• Long-term care

• Routine eye care (adult)

Dental care (adult)

• Personal development programs

• Infertility treatment

Private-duty nursing

 Routine foot care (unless you have been diagnosed with diabetes. Consult your formal contract of coverage

Other Covered Services (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)

- Acupuncture
- Bariatric surgery (For morbid obesity. Consult your formal contract of coverage)
- Chiropractic care
- Hearing Aids (Up to **\$1,000** every 36 months)
- Most coverage provided outside the United States.

See www.BCBS.com/bluecardworldwide

Your Rights to Continue Coverage: "If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights, maybe limited in duration and will require you to pay a premium, which may be significantly higher than the premium you pay while covered under the plan,. Other limitations on your rights to continue coverage may also apply. For more information on your rights to continue coverage, contact the plan at 1-877-737-7776. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or <a href="https://www.dol.gov/ebsa">www.dol.gov/ebsa</a> or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or <a href="https://www.cciio.cms.gov">www.cciio.cms.gov</a>

Your Grievance and Appeals Rights: If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, considered an Adverse Benefit Determination (ABD) you may be able to <u>appeal</u> or file a <u>grievance</u>. For questions about your rights, this notice, or assistance, you can contact: Grievance and Appeals 1-877-737-7776

Anthem Blue Cross Attention: Grievance and Appeals P.O. Box 60007 Los Angeles, CA 90060-0007

If Anthem Blue Cross upholds the ABD, that decision becomes a Final Adverse Benefit Determination (FABD) and you may request an independent External Review. If you are not satisfied with Anthem Blue Cross' FABD, the independent External Review decision or you do not want to pursue the independent External Review Process, you may request an Administrative Review from CalPERS. The request must be mailed to:

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CalPERS Health Plan Administration Division/ Appeals Coordinator

P.O. Box 1953

Sacramento, CA 95812-1953

#### **Does this Coverage Provide Minimum Essential Coverage?**

The Affordable Care Act requires most people to have health care coverage that qualifies as "minimum essential coverage."

This plan or policy does provide minimum essential coverage.

#### **Does this Coverage Meet the Minimum Value Standard?**

The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). This health coverage does meet the minimum value standard for the benefits it provides.

#### **Language Access Services:**

Si no es miembro todavía y necesita ayuda en idioma español, le suplicamos que se ponga en contacto con su agente de ventas o con el administrador de su grupo. Si ya está inscrito, le rogamos que llame al número de servicio de atención al cliente que aparece en su tarjeta de identificación.

如果您是非會員並需要中文協助,請聯絡您的銷售代表或小組管理員。如果您已參保,則請使用您 ID 卡上的號碼聯絡客戶服務人員。

Kung hindi ka pa miyembro at kailangan ng tulong sa wikang Tagalog, mangyaring makipag-ugnayan sa iyong sales representative o administrator ng iyong pangkat. Kung naka-enroll ka na, mangyaring makipag-ugnayan sa serbisyo para sa customer gamit ang numero sa iyong ID card.

Doo bee a'tah ni'liigoo eí dooda'í, shikáa adoolwol íinízinigo t'áá diné k'éjíígo, t'áá shoodí ba na'alníhí ya sidáhí bich'i naabídíílkiid. Eí doo biigha daago ni ba'nija'go ho'aalagíí bich'i hodiilní. Hai'daa iini'taago eíya, t'áá shoodí diné ya atáh halne'ígíí ní béésh bee hane'í wólta' bi'ki si'niilígíí bi'kéhgo bich'i hodiilní.

아직 가입하지 않았거나 한국어로 된 도움말이 필요한 경우 영업 관리자나 그룹 관리자에게 문의하시기 바랍니다. 이미 가입한 경우 ID 카드에 있는 번호를 사용하여 고객 서비스에 문의하시기 바랍니다.

Nếu quý vị chưa phải là một hội viên và cần được giúp đỡ bằng Tiếng Việt, xin liên lạc với đại diện thương mãi của quý vị hoặc quản trị viên nhóm. Nếu quý vị đã ghi danh, xin liên lạc với dịch vụ khách hàng qua việc dùng số điện thoại ghi trên thẻ ID của quý vị.

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## **About these Coverage Examples:**

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.



# This is not a cost estimator.

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

#### Having a baby

(normal delivery)

- Amount owed to providers: \$7,540
- Plan pays \$5,530
- Patient pays \$2,010

#### Sample care costs:

Laboratory tests Prescriptions Radiology Vaccines, other preventive	\$7,540
Laboratory tests Prescriptions	\$40
Laboratory tests	\$200
	\$200
	\$500
Anesthesia	\$900
Hospital charges (baby)	\$900
Routine obstetric care	\$2,100
Hospital charges (mother)	\$2,700

#### Patient pays:

ralielii pays.	
Deductibles	\$500
Copays	\$10
Coinsurance	\$1,350
Limits or exclusions	\$150
Total	\$2,010

#### **Managing type 2 diabetes**

(routine maintenance of a well-controlled condition)

- Amount owed to providers: \$5,400
- Plan pays \$4,190
- Patient pays \$1,210

#### Sample care costs:

Prescriptions	\$2,900
Medical Equipment and Supplies	\$1,300
Office Visits and Procedures	\$700
Education	\$300
Laboratory tests	\$100
Vaccines, other preventive	\$100
Total	\$5,400

#### Patient pays:

Deductibles	\$500
Copays	\$390
Coinsurance	\$240
Limits or exclusions	\$80
Total	\$1,210

Questions: Call 1-877-737-7776 or visit us at www.anthem.com/ca/calpers

If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at www. anthem.com/ca/calpers or call 1-877-737-7776 to request a copy.

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#### **Questions and answers about the Coverage Examples:**

# What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums**.
- Sample care costs are based on national averages supplied by the U.S.
   Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from innetwork <u>providers</u>. If the patient had received care from out-of-network <u>providers</u>, costs would have been higher.

## What does a Coverage Example show? For each treatment situation, the Coverage Example helps you see how

deductibles, Copayments, and Coinsurance can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

### Does the Coverage Example predict my own care needs?

No. Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

### Does the Coverage Example predict my future expenses?

No. Coverage Examples are <u>not</u> cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your <u>providers</u> charge, and the reimbursement your health plan allows.

### Can I use Coverage Examples to compare plans?

Yes. When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

# Are there other costs I should consider when comparing plans?

Yes. An important cost is the <u>premium</u> you pay. Generally, the lower your <u>premium</u>, the more you'll pay in out-of-pocket costs, such as <u>Copayments</u>, <u>deductibles</u>, and <u>Coinsurance</u>. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.